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GMM

12 Dec 90

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Brett, Charlie and Jon:

It's time to think DU, if you haven't already done so. The enclosure provides data useful for projecting crew exposures should you receive inquiries in that area. My review of the data leads me to conclude that there should be no reason to have to issue dosimeters, but y'all can better assess that on the basis of real world experience in the sand pile over there.

One of the obvious concerns to all personnel including medical staff will be the risks associated with DU smoke, when munitions burn in armored vehicles. In those cases, the potential for uranium oxides as airborne particulates in the smoke will exist. The approach medically is no different than the approaches used for chemical agent contamination or other radiological contaminants, and you use the same doctrine. The risk to the patient and medical staff, however, is far less severe. The radiological activity is extremely low, so the casualty is not an external radiation risk to other people (patients or medical staff). Wound contamination is a possibility, but again, the radiological risk is extremely low compared to all other health risks. In fact, toxic heavy metal poisoning is a greater internal threat than the radioactivity, but that too is an extremely low risk compared to all other health risks. The main effort (after life and limb saving) must be to reduce the risk of contamination spread, with particular emphasis on cross contamination in medical facilities by staff and medical tools. Removal of casualty outer garments will get rid of 90% or more of the problem. Washing of skin and hair not previously covered by clothing will get virtually all of the rest, and water or soap and water should be adequate. Clothing and linens can be run through ordinary laundering and equipment can be washed, and then these items can be returned to service. Triage of casualties suspected of contamination is the same, but control of the potential spread of DU can be simplified if they can be segregated from casualties known NOT to be contaminated. Since there are probably not enough appropriate instruments to monitor DU or the degree of decontamination success of suspect

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12 Dec 90

people, equipment or areas, I suggest decon be done as quickly and thoroughly as conditions permit, and the resulting effort be considered "good to go" as clean until demonstrated otherwise. The low degree of health risk can permit this approach, even though you would not want to do this with chem agents or other radioisotopes.

The 12th PVNTMED is now over there. 1LT Rokke is the 68B with that unit. The odds are very good that he knows little to nothing about the main 68B issues facing you all, so please try to locate him, and bring him up to speed. Share the materials I have sent you. I'll start including him in the correspondence as soon as I can get an APO number on him. The next "68B" headed your way in a Reserve Unit appears to be CPT R. Gibbons. I have no information on him other than an opinion that he seems to be full of himself. He may have less technical experience than 1LT Rokke.

In my opinion Jon and Charley should by now have some sort of liaison established with G-2 sources so that they can rapidly acquire threat information needed to project casualties from battle events of 68B importance. The treatment facilities under your MED GRPs need as much advance planning support as can be reliably provided for these types of situations, because they have special impacts on medical unit deployment, medical logistics and patient handling.

Regards, C. E. Day, III

*This is my second
letter to y'all collectively.
Hope you got the first one!
CE Day*